TEXAS DEPARTMENT OF INSURANCE
Division of Workers' Compensation - Medical Fee Dispute Resolution (MS-48)
7551 Metro Center Drive, Suite 100, Austin, Texas 78744-1645
(512) 804-4000 | F: (512) 804-4811 | (800) 252-7031 | TDI.texas.gov | @TexasTDI

MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name
ORTHO TEXAS PHYSICIANS & SURGEONS, PLL

Respondent Name
AMERICAN ZURICH INSURANCE COMPANY

MFDR Tracking Number
M4-16-1599-01

Carrier's Austin Representative
Box Number 19

MFDR Date Received
February 9, 2016

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "This claim . . . was originally submitted to York Risk Services because that was the carrier responsible for this work related injury. It was discovered on 9/7/2015 that York Risk Services is no longer the carrier for this case but all claims should be sent to Corvel. After getting the correct claims number for this particular injury and a case set-up for this claim to be submitted to Corvel the claim was sent for processing."

Amount in Dispute: $2,633.00

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "Corvel Received the original bill . . . on 10/19/15 via fax. Further, the Requestor say they found out Corvel was the TPA in October 2015 – as such, their Clearinghouse Vendor could not have sent the bill to Corvel on 6/22/15."

Response Submitted by: CorVel

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
June 12, 2015	Ambulatory Surgical Services	$2,633.00	$2,633.00

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and applicable rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Texas Administrative Code §133.307 sets out the procedures for resolving medical fee disputes.
2. 28 Texas Administrative Code §133.20 sets out medical bill submission procedures for health care providers.
3. 28 Texas Administrative Code §134.402 sets out the medical fee guideline for ambulatory surgery centers.
4. Texas Labor Code §408.027 sets out provisions related to payment of health care providers.
5. Texas Labor Code §408.0272 provides for certain exceptions to untimely submission of a medical claim.

6. The insurance carrier reduced payment for the disputed services with the following claim adjustment codes:
   - 29 – Time Limit for Filing Claim/Bill has Expired
   - RM2 – Time limit for filing claim has expired
   - RT – Right Side
   - W3 – Appeal/Reconsideration

Issues

1. What is the timely filing deadline applicable to the medical bills for the services in dispute?
2. Is the requestor entitled to additional payment?

Findings

1. The insurance carrier denied the disputed services with claim adjustment reason codes: 29 – "Time Limit for Filing Claim/Bill has Expired"; and RM2 – "Time limit for filing claim has expired."

   28 Texas Administrative Code §133.20(b) requires that:

   > Except as provided in Labor Code §408.0272(b), (c) or (d), a health care provider shall not submit a medical bill later than the 95th day after the date the services are provided. In accordance with subsection (c) of the statute, the health care provider shall submit the medical bill to the correct workers' compensation insurance carrier not later than the 95th day after the date the health care provider is notified of the health care provider's erroneous submission of the medical bill. A health care provider who submits a medical bill to the correct workers' compensation insurance carrier shall include a copy of the original medical bill submitted, a copy of the explanation of benefits (EOB) if available, and sufficient documentation to support why one or more of the exceptions for untimely submission of a medical bill under §408.0272 should be applied.

   Texas Labor Code §408.0272(b)(1)(C) provides that:

   > Notwithstanding Section 408.027, a health care provider who fails to timely submit a claim for payment to the insurance carrier under Section 408.027(a) does not forfeit the provider's right to reimbursement for that claim for payment . . . if . . . the provider submits proof satisfactory to the commissioner that the provider, within the period prescribed by Section 408.027(a), erroneously filed for reimbursement with . . . a workers' compensation insurance carrier other than the insurance carrier liable for the payment of benefits.

   The requestor submitted documentation to satisfactorily support that the health care provider erroneously filed for reimbursement with York—the workers' compensation insurance carrier previously liable for payment of benefits—within the time limit prescribed by Labor Code §408.027(a). Accordingly, the Division finds that the health care provider has met the requirements for an exception to the timely submission requirement of Rule §133.20(b).

   Per Rule §133.20(b) and Labor Code §408.0272(c), the health care provider was then required to submit the medical bill to the correct workers' compensation insurance carrier no later than the 95th day after the date the health care provider was notified. The submitted documentation supports that the health care provider was notified of the erroneous submission of the medical bill on September 17, 2015. The 95th day following the date of notification was Monday, December 21, 2015. CorVel, the agent for the insurance carrier, acknowledges receipt of the medical bill on October 19, 2015. This date is before the 95th day following the date of notification of erroneous submission. Consequently, the requestor has supported timely submission of the medical bill to the correct carrier.

   The insurance carrier's denial reasons are not supported; the disputed services will therefore be considered for reimbursement according to applicable Division rules and fee guidelines.

2. This dispute regards ambulatory surgery services with reimbursement subject to the provisions of 28 Texas Administrative Code §134.402(f), which states:

   > The reimbursement calculation used for establishing the MAR shall be the Medicare ASC reimbursement amount determined by applying the most recently adopted and effective Medicare Payment System

Policies for Services Furnished in Ambulatory Surgical Centers and Outpatient Prospective Payment System reimbursement formula and factors as published annually in the Federal Register. Reimbursement shall be based on the fully implemented payment amount as in ADDENDUM AA, ASC COVERED SURGICAL PROCEDURES FOR CY 2008, published in the November 27, 2007 publication of the Federal Register, or its successor. The following minimal modifications apply:
(1) Reimbursement for non-device intensive procedures shall be:
(A) The Medicare ASC facility reimbursement amount multiplied by 235 percent

Reimbursement is calculated as follows:

- Procedure code 24342, service date June 12, 2015, has status indicator A2, denoting an ASC procedure reimbursed in accordance with §134.402(f)(1)(A). Per Addendum AA, the payment rate for this procedure is $2,061.95. This amount is divided into two halves representing the labor-related and non-labor-related portions of $1,030.98 each. The unadjusted labor-related portion is multiplied by the annual wage index of 0.9703 for the facility location to determine the geographically adjusted labor-related portion of $1,000.36. This amount is added back to the non-labor half; the sum is the Medicare ASC facility reimbursement amount of $2,031.33. This amount multiplied by the Division's conversion factor of 235% results in a MAR of $4,773.63.

3. The total recommended payment for the services in dispute is $4,773.63. The insurance carrier has paid $0.00. The requestor is seeking $2,633.00. This amount is recommended.

Conclusion

The Division finds that the requestor has established that additional reimbursement is due.
As a result, the amount ordered is $2,633.00.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code Sections 413.031 and 413.019 (if applicable), the Division has determined that the requestor is entitled to additional reimbursement for the services involved in this dispute. The Division hereby ORDERS the respondent to remit to the requestor the amount of $2,633.00 plus applicable accrued interest per 28 Texas Administrative Code §134.130, due within 30 days of receipt of this Order.

Authorized Signature

	Grayson Richardson	April 1, 2016
Signature	Medical Fee Dispute Resolution Officer	Date

YOUR RIGHT TO APPEAL

Either party to this medical fee dispute has a right to seek review of this decision in accordance with 28 Texas Administrative Code §133.307, 37 *Texas Register* 3833, applicable to disputes filed on or after June 1, 2012.

A party seeking review must submit a **Request to Schedule a Benefit Review Conference to Appeal a Medical Fee Dispute Decision** (form **DWC045M**) in accordance with the instructions on the form. The request must be received by the Division within **twenty** days of your receipt of this decision. The request may be faxed, mailed or personally delivered to the Division using the contact information listed on the form or to the field office handling the claim.

The party seeking review of the MFDR decision shall deliver a copy of the request to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §141.1(d).

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.